REPORT OF SERIOUS OCCURRENCE

State Form 52384 (9-05)

Indiana Protection and Advocacy Services (IPAS)
4701 N. Keystone Ave., Suite 222
Indianapolis, IN 46205
Fax (317) 722-5564 Voice 800-622-4845

INSTRUCTIONS: 1. Psychiatric Residential Treatment Facilities (PRTF) as defined in 42 CFR § 483.352 MUST report any serious occurrence involving a resident to both the State Medicaid agency (Office of Medicaid Policy and Planning) and the Indiana Protection and Advocacy Services (IPAS) by no later than the close of business of the next business day after a serious occurrence.

2. *The report must be completed and faxed to* (317) 722-5564, *IPAS, by no later than 4:30 p.m. of the next business day after a serious occurrence. The sending facility needs to then initiate a voice confirmation of the successful receipt of the fax by IPAS by calling* 1-800-622-4845.
3. *The completed report must also be faxed to (317) 232-7382, Attention: Director of Program Operations-Acute Care, Office of Medicaid Policy and Planning, by no later than 4:30 p.m. of the next business day after a serious occurrence.*
4. *The DEATH of a resident MUST be reported to Centers for Medicare and Medicaid Services (CMS) by no later than 6:00 p.m. Central Time on the next business day after the resident's death. Fax: (312) 886-2303 Voice: (312) 353-0519 Requirements for documenting reports of serious occurrences are set out in 42 CFR § 483.374.*

FACILITY INFORMATION

Name of facility	*Telephone number (area code-XXX-XXX)*

Address (number and street, city, state, zip code)

Name of individual completing this report	*Position/Title*

Telephone number (area code-XXX-XXX)	*Extension*	*Today's date (month, day, year)*

RESIDENT INFORMATION

Name of resident (First, M.I., Last)	*Date of birth (month, day, year)*
Admission date (month, day, year)	*Gender of resident* ☐ Male ☐ Female

GUARDIAN OF RESIDENT INFORMATION

Name of guardian (First, Last)	*Relationship of guardian to resident*
Address (number and street, city, state, ZIP code)	*Telephone number (area code-XXX-XXX)*

Enter the date and time the guardian was notified of serious occurrence.

Date (month, day, year)	*Time* ☐ AM ☐ PM	*Name and title of staff that contacted guardian*

Was Child Protective Services (CPS) notified of the SERIOUS OCCURRENCE?	☐ Yes	☐ No
Was Adult Protective Services (APS) notified of the SERIOUS OCCURRENCE?	☐ Yes	☐ No

SERIOUS OCCURRENCE INFORMATION

Date of serious occurrence (month, day, year)	*Time*	*Location of serious occurrence (ward/unit/area)*
	☐ AM ☐ PM	

Type of serious occurrence

☐ Death ☐ Suicide Attempt ☐ Serious Injury

Pursuant to 42 CFR 483.374(c), you must report a resident's DEATH, by no later than close of business on the next business day after the resident's death, directly to: Health Insurance Specialist, Centers for Medicare and Medicaid Services (CMS), Chicago, Illinois Telephone (voice): (312) 353-0519 Fax: (312) 886-2303 Reports are accepted between 6:30 a.m. and 6:00 p.m. Central Time (Chicago observes Daylight Saving Time April through October)

Enter the date and time the resident's death was reported directly to CMS:

Date (month, day, year)	*Time*	Is the report to CMS documented in the resident's record as required?
	☐ AM ☐ PM	☐Yes ☐No

Did the SERIOUS OCCURRENCE occur during the use of either restraint or seclusion? ☐Yes ☐No

Provide a description of the occurrence (attach additional sheets if needed)

Number of additional sheets added (if none then write None)	